



Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: RENAISSANCE HOSPITAL C/O BURTON & HYDE PLLC PO BOX 684749 AUSTIN TX 78768-4749	MFDR Tracking #: M4-07-1988-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: AMERICAN CASUALTY CO OF READING Box #: 47	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...the fair and reasonable reimbursement amount for this hospital outpatient admission should be commensurate with the average amount paid by all insurance carriers in the Texas workers' compensation system in the same year as this admission for those admissions involving the same Principal Diagnosis Code and Principal Procedure Code."

Amount in Dispute: \$46,839.34

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not timely submit a response to the request for Medical Fee Dispute Resolution and has waived the right to respond.

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
12/7/05	97, 42, W1, D20, 50, W10, B13, W4	Outpatient Surgery	\$46,839.34	\$6,577.96
			Total Due:	\$6,577.96

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on November 20, 2006. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on December 1, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. U.S. Bankruptcy Judge Michael Lynn issued a "STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS," dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the Claim Adjudication Process as to the Workers' Compensation Receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 Trustee of the debtor's estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer's behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.
2. By letter dated May 26, 2011, the attorney for the requestor provided *REQUESTOR'S AMENDED POSITION STATEMENT (RENAISSANCE HOSPITAL – DALLAS)* that specified, in pertinent parts, an "Additional Reimbursement Amount Owed" of \$13,818.00 and an "alternative" "Additional Reimbursement Amount Owed" of \$12,753.69. The Division notes that the amount in dispute of \$46,839.34 specified in Part IV above is the original amount in dispute as indicated in the requestor's *TABLE OF DISPUTED SERVICES* submitted prior to the *REQUESTOR'S AMENDED POSITION STATEMENT*.

3. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
- 97—Payment is included in the allowance for another service/procedure
 - 42—Charges exceed our fee schedule or maximum allowable amount
 - W1—Workers compensation state fee schedule adjustment
 - D20—Claim/service missing product information
 - 50—These services are non-covered services because this is not deemed a 'medical necessity' by the payer
 - W10—No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement
 - B13—Previously paid. Payment for this claim/service may have been provided in a previous payment
 - W4—No additional reimbursement allowed after review of appeal/reconsideration
4. The insurance carrier denied disputed services with reason code 50 - "These services are non-covered services because this is not deemed a 'medical necessity' by the payer." Former Division rule at 28 TAC §133.301, effective July 15, 2000, 25 TexReg 2115, states, in pertinent part, that "The insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization under Chapter 134 of this title (relating to Guidelines for Medical Services, Charges, and Payments)." Review of the submitted information finds documentation to support that the health care provider obtained preauthorization for the disputed services. The Division further finds that the insurance carrier performed a retrospective review of the medical necessity of the medical bill for treatment(s) and/or service(s) for which the health care provider had obtained preauthorization. The insurance carrier has therefore failed to meet the requirements of §133.301. This denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
5. This dispute relates to services with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
6. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
7. Division rule at 28 TAC §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
- The requestor's amended position statement asserts that "the fair and reasonable reimbursement amount for this hospital outpatient admission should be commensurate with the average amount paid by all insurance carriers in the Texas workers' compensation system in the same year as this admission for those admissions involving the same Principal Diagnosis Code and Principal Procedure Code."
 - In support of the requested reimbursement methodology the requestor states that "Ordering additional reimbursement based on the average amount paid system-wide in Texas achieves effective medical cost control because it prevents overpayment... creates an expectation of fair reimbursement; and... encourages health care providers to continue to offer quality medical care to injured employees... Ordering additional reimbursement for at least the average amount paid for a hospital outpatient admission during the same year of service and involving the same Principal Diagnosis Code and Principal Procedure Code ensures that similar procedures provided in similar circumstances receive similar reimbursement... The average amount paid for similar admissions as put forward by the Requestor is based on a study of data maintained by the Division."
 - The requestor submitted documentation to support the state-wide, annual, average reimbursement in Texas for the principal diagnosis code and principal procedure code of the disputed services during the year that the services were rendered.
 - The requestor has explained and supported that the requested reimbursement methodology would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for additional reimbursement is supported. Thorough review of the submitted documentation finds that the requestor has discussed, demonstrated, and justified that the average amount paid by all insurance carriers in the Texas workers' compensation system in the same year as the disputed admission for those admissions involving the same principal diagnosis code and principal procedure code is a fair and reasonable rate of reimbursement for the services in dispute.

8. In the alternative, the requestor proposes that "it is justifiable to order additional reimbursement under the Hospital Facility Fee Guidelines – Outpatient because the Division's new fee guidelines, while not in effect at that time, are presumptively fair and reasonable reimbursement under the law and data from the Medicare Outpatient Prospective Payment System for this date of service is available for calculating the amount due." Review of the submitted documentation finds that:

- In support of the alternative requested reimbursement methodology the requestor states that “The data necessary to calculate the Maximum Allowable Reimbursement for this year of service is readily available from the Medicare Outpatient Prospective Payment System. Therefore, the new fee guidelines as adopted in 28 TEX. ADMIN. CODE § 134.403 provide a presumptive measure for the fair and reasonable reimbursement amount.”
- The requestor did not submit documentation to support the Medicare payment calculation for the services in dispute.
- The fee guidelines as adopted in Division rule at 28 TAC §134.403 were not in effect during the time period when the disputed services were rendered.
- The Division disagrees that the fee guidelines as set forth in §134.403 are “presumptively fair and reasonable reimbursement under the law” for dates of service prior to the date the rule became effective. No documentation was found to support such a presumption under law.
- While the Division has previously found that Medicare patients are of an equivalent standard of living to workers’ compensation patients, (22 TexReg 6284, July 4, 1997), Texas Labor Code Section 413.011(b) requires that “In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d)... This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services.”
- The requestor did not discuss or present documentation to support how applying the proposed payment adjustment factors as adopted in Division rule at 28 TAC §134.403, effective for dates of service on or after March 1st, 2008, would provide fair and reasonable reimbursement for the disputed services during the time period that treatment was rendered to the injured worker.
- The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for the alternative additional amount of \$12,753.69 is not supported. The requestor has not demonstrated or presented sufficient documentation to support that the alternative additional amount requested of \$12,753.69 would provide a fair and reasonable rate of reimbursement for the services in dispute.

9. Division rule at 28 TAC §133.307(i), effective January 1, 2003, 27 TexReg 12282, states that “A respondent who fails to timely file a response waives the right to respond. The commission shall deem a response to be filed on the date the division receives a response. If the respondent does not respond timely, the commission shall issue a decision based on the request. The response will be considered timely if received by the commission within 14 days after the date the respondent received the copy of the requestor’s additional documentation.” Review of the submitted documentation finds that a response was not received by the commission within 14 days after the date the respondent received the copy of the requestor’s additional documentation. The Division concludes that the respondent has failed to meet the requirements of §133.307(i) and has waived the right to respond. The Division will therefore issue a decision based on the request.
10. Division rule at 28 TAC §133.307(j)(1)(E)(iv), effective January 1, 2003, 27 TexReg 12282, requires that each response shall include a statement of the disputed fee issue(s), which includes “a discussion regarding how the submitted documentation supports the respondent position for each disputed fee issue.” Review of the submitted documentation finds that the respondent has not discussed how the submitted documentation supports the respondent position for each disputed fee issue. The Division concludes that the respondent has not met the requirements of §133.307(j)(1)(E)(iv).
11. Division rule at 28 TAC §133.307(j)(1)(F), effective January 1, 2003, 27 TexReg 12282, requires that each response shall include “if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code §413.011 and §§133.1 and 134.1 of this title.” Review of the submitted documentation finds that:
 - The respondent did not timely submit a response to the request for Medical Fee Dispute Resolution and has waived the right to respond.
 - The respondent did not submit documentation to support that the amount paid is a fair and reasonable rate of reimbursement.
 - The respondent did not explain how the amount paid satisfies the requirements of Division rule at 28 TAC §134.1.
 The respondent’s position is not supported. Thorough review of the submitted documentation finds that the respondent has not demonstrated or justified that the amount paid is a fair and reasonable rate of reimbursement for the services in dispute. The Division concludes that the respondent has not met the requirements of Division rule at 28 TAC §133.307(j)(1)(F).

12. The Division finds that the documentation submitted in support of the fair and reasonable methodology proposed by the requestor based on the average amount paid by all insurance carriers in the same year for admissions involving the same principal diagnosis code and principal procedure code as the services in dispute is the best evidence in this dispute of an amount that will achieve a fair and reasonable reimbursement for the services in this dispute. Reimbursement will therefore be calculated as follows. Review of the medical bill finds that the principal diagnosis code for the disputed services is 722.0. The principal procedure code is 80.51. The requestor submitted documentation to support that the average, state-wide reimbursement for this diagnosis code and procedure code performed in 2005 was \$13,818.00. This amount less the amount previously paid by the respondent of \$7,240.04 leaves an amount due to the requestor of \$6,577.96. This amount is recommended.
13. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the requestor has established that additional reimbursement is due. The Division concludes that the carrier's response was not submitted in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the respondent failed to support that the amount paid by the insurance carrier is a fair and reasonable reimbursement in accordance with Division rule at 28 Texas Administrative Code §134.1. As a result, the amount ordered is \$6,577.96.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1, §134.403
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$6,577.96 plus applicable accrued interest per Division rule at 28 Texas Administrative Code §134.803, due within 30 days of receipt of this order.

ORDER:

Margaret Q. Ojeda

Authorized Signature

Medical Fee Dispute Resolution Officer

Date

Martha Luevano

Authorized Signature

Medical Fee Dispute Resolution Officer

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.